SUMMARY OF RECOMMENDATIONS

The recommendations listed in the summary are extracted from the full text of the RIW report. Please refer to the relevant sections for a full explanation, context, and rationale.

Recommendations to Uphold Core Principles and Responsibilities to American Indians and Alaska Natives

2.1 The Administration, Congress, and Federal agencies must recognize the sovereign status of Indian Tribes.

2.2 The HHS must expand its services into American Indian and Alaska Native communities as a part of carrying out the Federal trust responsibility for health care services to Indian people.

2.3 The position of IHS Director must be elevated to the Assistant Secretary level within HHS to strengthen the government-to-government relationship between the United States and Tribes.

2.4 The President must appoint a liaison in the White House for Tribal Leaders and Indian organizations to 1) inform the Administration on the status of Tribes, 2) assist the Administration in addressing the consultation directives and policies related to American Indian and Alaska Native people and their communities, and 3) explore ways to address Indian issues.

2.5 The HHS Secretary must provide to Tribal Governments direct eligibility for HHS grants and access to funds from other HHS agencies that are normally reserved only for states.

2.6 The HHS Secretary must issue a directive that all savings derived from IHS restructuring be exclusively reinvested in IHS mission-related activities.

2.7 The HHS Secretary must issue a letter about the One-HHS initiative to Tribal Leaders to initiate Tribal consultation.

2.8 The HHS Secretary must activate the Intradepartmental Council on Native American Affairs.

2.9 The HHS Secretary must regularly meet with Tribal Leaders to address how HHS can better address Indian health issues.

2.10 The HHS Secretary must exempt the IHS from full-time equivalent (FTE) and budget reductions since the Agency is under funded and had recently restructured in order to shift administrative resources to direct services in communities where Indian people are served.

2.11 Tribes must be consulted about the IHS/HHS/OMB budget early in the formulation process.

2.12 The IHS and HHS must consider the recommendations of the IHS/Tribal Public Health Support Workgroup and the Strategic Plan Workgroup.

2.13 The IHS and HHS must advocate for the Indian Health Care Improvement Act to become permanent legislation.

2.14 The IHS must clarify its Patient Bill of Rights to ensure both a high quality and level of services for American Indian and Alaska Native patients.

Recommendation to Revise the IHS Foundation, Mission, and Goals

4.1 Adopt the proposed foundation, mission, and goal statements to replace the existing statements.

Recommendations to Address the "One-HHS" Restructuring Initiative

5.1 Maintain Legislative and Public Affairs staffs in IHS to ensure that HHS gets timely information from and well-informed analysis about Indian Country.

5.2 The IHS Legislation and Public Affairs staffs will coordinate closely with other HHS agencies in national emergencies and on cross-cutting issues to ensure cohesion of the HHS message.

5.3 Use performance contracts and inter-agency agreements to ensure IHS accountability to the Secretary for a cohesive approach to legislation and public information.
5.4 Realign Human Resource (HR) support functions within IHS to take advantage of new technologies and enhance expertise available to all IHS sites in 35 States.
5.5 Avoid consolidating IHS' specialized experience and support for the dispersed community-based health care system with highly dissimilar agencies.
5.6 Implement operational improvements with the IHS to achieve performance goals envisioned by the Secretary.
5.7 Retain the IHS health care facilities and sanitation construction programs within the IHS to ensure its mission-critical focus is maintained.
5.8 Endorse HHS steps to better manage federal office space that does not impact front-line Indian health care facilities.
5.9 Use a memorandum of agreement to ensure full reporting and compliance of IHS facilities data with HHS standards.
5.10 The HHS should support increased funding to address aged and inadequate health facilities in Indian Country.
5.11 Ensure that IHS reforms accommodate and affirm Tribal rights to compact, contract, or retain IHS to operate health programs directly.
5.12 Track all realigned resources to ensure that resources available to the Tribes (known as Tribal shares) are not reduced as consequence of reforms.
5.13 Apply all savings resulting from restructuring to additional health care services for Indian people.
5.14 Fully fund contract support costs and other one-time costs of transition to remove the impediment for additional Tribal contracting and compacting.
5.15 Assess the structure and capacity of the Office of Tribal Programs, headquarters direct support programs, and the IHS Urban Indian Health Program Office to complement the assessment already completed for the Office of Tribal Self-Governance.
5.16 Assure a balanced capability among these offices in accordance with the actual mix of self-determination contracts and compacts, IHS direct programs, and Urban Indian Health Programs.
5.17 Identify contingency plans to minimize service disruptions for any tribe potentially affected by retrocession of a contract or compact to the IHS.
5.18 Manage transfer of Tribal shares to ensure a smooth and orderly transition of programs, activities, functions, and services to all Tribes.

Recommendations to Eliminate Indian Health Disparities and Sustain Wellness for Indian People

6.1 Double IHS funding on a per capita basis to bring resources for Indian health in line with those available to other Americans.
6.2 Ensure eligibility for Tribes and urban Indian health organizations to access and share in health care resources of other HHS agencies.
6.3 Double the number health care providers in the Indian health care system.
6.4 Eliminate shortages of doctors, dentists, pharmacists, nurses and other health care providers in Indian Country through better recruitment, training, and compensation.
6.5 Replace, expand, and modernize aged inadequate hospitals and ambulatory clinics for a growing Indian population.
6.6 Invest in community infrastructure, especially for safe water supply and waste disposal—forms infrastructure that are virtually non-existent in remote areas of Indian Country.
6.7 Encourage and support traditional Tribal healers, cultural practices and principles;
6.8 Emphasize Indian beliefs, ceremonies, and traditional practices of harmony and health as grounding for individual identity and personal self-worth — especially for young people;
6.9 Devote appropriate resources to wellness and prevention programs targeted to lifestyle including diet, exercise, and the avoidance of risky behaviors;

6.10 Recognize the whole person, extending to family, clan, Tribe, economic, and spiritual elements;
6.11 Reinforce Tribal values that encourage healthy choices and discourage harmful activities;
6.12 Support Tribal governance and infrastructure to provide a stable basis for community and individual development;
6.13 Build a viable economic base for employment in Indian communities, sustainable income, and means for self-support;
6.14 Renew a healthy environment, in conjunction with other Federal agencies, by correcting environmental damage (toxic waste, dioxins in rivers, etc.) and preserving opportunities for hunting, fishing, and gathering from the land, rivers, and seas much as Indian people have done for thousands of years.

Recommended Focus Areas during the next 5-7 Years

7.1 Make disease prevention the key objective
7.2 Focus on behavior and lifestyle
7.3 Strengthen public health capacity
7.4 Invest in information technology
7.5 Workforce: re-examine the mix, strengthen recruitment and retention
7.6 Adapt facilities for a broader approach to health
7.7 Adapt administrative support capacity to emerging trends
7.8 Reinforce linkages among I/T/Us
7.9 Assure that administrators are knowledgeable about healthcare
7.10 Market as the "system of choice"

Recommended Internal Reforms during the next 5-7 years

8.1 Realignment will improve consistency, quality, and timeliness of administrative support to front line health programs.
8.2 A regional configuration offers the best combination of potential savings, improved support service, and lower transition costs.
8.3 No IHS Area Office will close.
8.4 It is not feasible or appropriate to regionalize all administrative functions.
8.5 Combined savings of approximately 100-150 FTE and approximately $5 million – $7.5 million can be realized by realigning some administrative functions into regional teams.
8.6 Direct all savings from regionalization (estimated at 100-150 FTE and $5-$7.5 million) into health care services for Indian people.
8.7 Preserve and track every Tribe's "shares" of realigned FTE and resources.
8.8 Honor existing commitments that obligate Area Offices or headquarters to provide support services in a fashion specified in a binding agreement.
8.9 Regionalize appropriate administrative functions in a phased incremental fashion designed to avoid disruptions, develop and test new operational methods, and minimize conversion costs and employee relocations.
8.10 Phase-One: In-Place Regionalization: Begin regionalizing administrative organizational structures, span of support, and operational practices to create regional support teams "In-Place."
8.11 Phase-Two: Regionalization With Geographic Co-Location of Staff: After a period to develop and implement new regional support teams, and if initial results from phase-one are unsatisfactory, relocate appropriate administrative staff into 3 regional support centers.
8.12 The RIW endorses IHS patient workload benchmarks for determining the size and type of facility based on patient workload and population.

8.13 When applying patient workload benchmarks to plan new or replacement facilities, consider community input as an additional factor and maintain some planning flexibility consistent with assuring a safe and cost effective facility.
8.14 The RIW endorses the Facilities Appropriation Advisory Board (FAAB—a joint IHS/Tribal facilities construction workgroup) process for modifying the IHS facility construction priority system including necessary tribal consultation before adopting revisions to the priority system.
8.15 The most significant obstacle in addressing facility deficiencies is the lack of resources for construction.
8.16 The RIW does not recommend further consolidation or dispersal at this time of engineering functions now located in Dallas and Seattle.
8.17 The RIW recommends further study of whether Indian Country will benefit if the IHS assumes a "leadership" role for some HHS facility and engineering functions.
8.18 The RIW endorses no-cost measures to streamline planning, design, and construction as proposed by the IHS.
8.19 Adopt and implement a new IHS business Plan when delivered by the Business Plan Workgroup.
8.20 Develop a coordinated approach to Bio-terrorism that participates with and shares bio-terrorism preparedness resources from other Federal and State agencies.
8.21 Triple investment in information and communications technology over the next five years.
8.22 Create an interconnected Indian Health Network for hundreds of widely dispersed health care sites to more effectively collaborate and pool information, expertise, and resources.
8.23 Standardize data systems and protocols to assure all locations work together using common standards for communication and interoperability.
8.24 Specify hardware and software standards to assure all sites maintain compatibility while preserving flexibility to select differing hardware.
8.25 Utilize compatible information systems developed in the larger, better funded federal health care systems such as Department of Defense and Department of Veterans Affairs.
8.26 Develop a national data warehouse where consolidated data is retrievable from all sites throughout the Indian Health Network.
8.27 Expand technical assistance capability within the IHS environmental health program by creating Environmental Safeguards Technical Assistance Teams.
8.28 Reconsider the user count definition employed in IHS resource allocation formulas to account for costs in all facilities used by the patient.
8.29 The IHS executive leadership will work to persuade the Secretary to make Indian Country a very high priority for the Presidential priority of eliminating health disparities.
8.30 The IHS will work with sister HHS agencies to identify their role and responsibilities to eliminate health disparities of Indian people and seek concrete commitments to fund programs for eliminating those disparities.
8.31 Charge the Interdepartmental Council for Native American Affairs with identifying former IHS and tribal employees in DHHS regional offices to be included in tribal issues workgroups and to advocate for Indian issues.
8.32 Charge the Interdepartmental Council for Native American Affairs with drafting and recommending to the Secretary an element to include in all HHS agency director's annual performance contracts, specifying target resource amounts to be dedicated for use in Indian country.
8.33 Assign senior IHS employees to other HHS agencies to pursue policy support and funding for Indian needs.
8.34 Pursue legislation to remove barriers (Title XIX) that prevent Tribes from contracting directly.
8.35 Establish a Center for Tribal Access to Resources chartered to assist Tribes to realize all resources for which they are eligible.